Part 5: Application and Start of Waiver Services

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Section 5.1: Request for Application

An individual or his/her guardian may apply for the Family Supports Waiver program through the local Bureau of Developmental Disabilities Services (BDDS) office. Individuals (or their guardians) have the right to apply without questions or delay.

To apply for the Family Supports Waiver, the individual or guardian must complete, sign, and date an Application for Long Term Care Services (State Form 4594) including the time of day that the application is signed. An individual who has not already applied for waiver services may also need to complete, sign, and date a DDRS Referral and Application (State Form 10057) located at http://www.in.gov/fssa/ddrs/3349.htm. Other individual or agency representatives may assist the individual or guardian in completing the application form and forward it to the BDDS office service the county in which the individual currently resides. The application may be submitted in person, by mail or by fax.

Upon receiving the waiver application, the BDDS staff must contact the individual and/or his/her guardian and discuss the process for determining eligibility for the waiver (documentation of an intellectual/developmental disability, Medicaid eligibility, and level of care). If the applicant is not a Medicaid recipient, he/she will be referred to the local Division of Family Resources to apply for Medicaid.

Applicants requesting and meeting specific Reserved Capacity (priority) criteria for entrance into the Community Integration and Habilitation Waiver program will be advised of those services and the availability of a funded priority slot. See **Section 5.6: Entrance into the Community Integration & Habilitation Waiver Program** of this manual for details.

Section 5.2: Medicaid Eligibility: How to Apply for Medicaid

Medicaid eligibility is required prior to the start of waiver services. The Family and Social Services Administration (FSSA) Division of Family Resources (DFR) is responsible for processing applications and establishing eligibility for state benefits including:

- Medicaid / Indiana health coverage plans
- Supplemental Nutrition Assistance Program (SNAP) / food assistance
- Temporary Assistance for Needy Families (TANF) / cash assistance

How do I know if I qualify?

- The Medicaid eligibility guide, hosted online at http://member.indianamedicaid.com/am-i-eligible/eligibility-guide.aspx.
- A screening tool that will help you see if you qualify for benefits is available online at http://www.DFRBenefits.IN.gov**.**

Where do I apply?

To apply for Medicaid and other DFR benefits, you will need to fill out and submit an application. You may apply online at or in person at a local office, or call 1-800-403-0864 to request an application be mailed to you.

Apply online Apply for benefits and complete your application using the electronic signature online at http://www.DFRBenefits.IN.gov. The online application is available 24 hours a day, 7 days a week. Applications received online Monday through Friday, after 4:30 p.m. local time, will be marked as applying on the next business day. If approved for benefits, you can use this link to help you manage your benefits, access your case information and report changes, such as a new address or phone number.If you do not have access to a computer in your home, computers with Internet access are available at your local DFR office and at DFR Enrollment Centers located around the state. Enrollment centers are places such as local hospitals and community health centers. For a list of Enrollment Centers, go online to http://www.in.gov/fssa/ompp/3030.htm or call toll-free 1-800-889-9949.

Apply in person Apply in person at your local DFR office, Monday through Friday, 8:00 a.m. to 4:30 p.m. A DFR office is located in every county in Indiana; with multiple offices located in Marion, Lake and St. Joseph counties.

Apply by mail Call toll free **1-800-403-0864** Monday through Friday between 8:00 a.m. and 4:30 p.m. to request an application be mailed to you. Complete the application and return it in the mail, FAX it toll free to 1-800-403-0864, or bring it into the DFR office in the county where you reside.

DFR office locations

To find a DFR office near you, go online to http://www.DFRBenefits.IN.gov. Enter your ZIP code in the search box provided, or click on the name of the county where you live in the table shown. This will take you to a page listing the address and other information about your local

office. If you do not have Internet access, call toll free 1-800-403-0864 and an operator will provide you with this information.

Checklist of information required to complete a Medicaid application

For **all of the people in your household**, will need to know:

- ❑ Names and dates of birth
- ❑ Social Security Number
- ❑ Relationship to applicant

For **only the applicant and individual(s) seeking benefits**, you will also need to know:

- ❑ Income from jobs or training
- ❑ Benefits you get now (or got in the past) such as Social Security, Supplemental Security Income (SSI), veteran's benefits, child support
- ❑ Amount of money in your checking account, savings accounts or other resources you own
- ❑ Monthly rent, mortgage payment and utility bills
- ❑ Payments for adult or child care Health coverage and/or medical benefits you currently have

You may go to the **http://www.DFRBenefits.IN.gov** web site to get the specific application instructions

How long is the approval process for Medicaid?

Once you submit your complete application, it will take about 45-90 days to determine if you are eligible. DFR may contact you by phone or by mail if additional information or documentation is required to complete your application.

Applicants under the age of 18 *should* submit the Plan of Care/Cost Comparison Budget (CCB) approval letter (described under Section 5.8 of this manual) to the Division of Family Resources (DFR) when submitting an application for Medicaid benefits or when requesting for a change of Medicaid Aid Category in order to qualify for waiver eligibility.

NOTE: Medicaid eligibility is required prior to the start of waiver services.

Section 5.3: Initial Level of Care Evaluation

An individual targeted for the Family Supports Waiver or meeting priority criteria and approved for entrance to Community Integration or Habilitation Waiver must meet the level of care required for placement in an Intermediate Care Facility for the Intellectually Disabled (ICF/ID).

Initial Level of Care determinations are made by the Bureau of Developmental Disabilities Services (BDDS) Service Coordinator after review of the evaluations and recommendations of a designated contractor, with the following exceptions:

- the individual targeted for waiver services is age five (5) or younger, or
- the individual is currently a resident of an ICF/ID facility and has been cited by the Indiana State
  Department of Health as being inappropriately placed, indicating a violation of a federal standard

Under these exceptions, the level of care determination is made by the DDRS Central Office.

Reevaluations are performed by the selected provider of Case Management services.

Qualifications of Individuals Performing Initial Evaluation: Only individuals (state employees) who are Qualified Mental Retardation Professionals (QMRP) as specified by the standard within 42 CFR 483.430(a) may perform initial Level of Care determinations.

Level of Care Criteria: If collateral records are not available or are not a valid reflection of the individual, additional assessments may be obtained from contracted psychologists, physicians, nurses and licensed social workers. Following review of the collateral records, the Level of Care Screening Tool (LOCSI) is completed, applicable to individuals with intellectual disability and other related conditions, in order to ascertain if the individual meets ICF/ID LOC.

The Level of Care Screening Tool (LOCSI) assessment is used for:

- Reviewing and referencing documentation related to the intellectual/developmental disabilities of the applicant/participant as well as any psychiatric diagnosis and results of the individual's intellectual assessment
- Recording age of onset
- Identifying areas of major life activity within which the individual may exhibit a substantial functional limitation, including the areas of mobility, understanding and use of language, self-care, capacity for independent learning, self direction, and, for the

state definition of developmental disability found in Indiana Code [IC 12-7-2-61], economic self sufficiency.

The BDDS Service Coordinator, LOC contractor (initial LOC) or selected provider of Case Manager (re-evaluations) reviews the LOCSI and collateral material, applicable to individuals with intellectual*/developmental disability and other related conditions, in order to ascertain if the individual meets ICF/ID LOC. An applicant/participant must meet three of six substantial functional limitations and each of four basic conditions (listed below) in order to meet LOC.

The basic conditions are:

- intellectual disability, cerebral palsy, epilepsy, autism, or other condition (other than a sole diagnosis of mental illness) similar to intellectual disability
- the ID, DD or other related condition is expected to continue indefinitely,
- the ID, DD or other related condition had an age of onset prior to age 22, and
- the ID, DD or other related condition results in substantial functional limitations in at least three (3) major life activities.

The substantial functional limitation categories, as defined in 42 CFR 435.1010, are:

- self-care,
- learning,
- self direction,
- capacity for independent living,
- understanding and use of language, and
- mobility.

*Intellectual disability is also known as mental retardation

Section 5.4: Waiting List for the Family Supports Waiver

It is the policy of the Bureau of Developmental Disabilities Services (BDDS) that individuals may be placed on a single statewide waiting list after applying for waiver services and meeting specified criteria. Individuals are responsible for maintaining current collateral and contact information with their local BDDS office.

Initial Placement on the single, statewide Home and Community Based Services Waiver Waiting List

- Individuals or their legal representative must complete an application and submit the application to their local BDDS office to apply for HCBS waiver services.
- Individual is expected to participate in the completion of the following:

- Application
- Collateral Information, including the following:
  - Level of Care Screening Instrument (LOCSI)
  - Supporting documents:
    - Diagnostic Evaluation(s)
    - Functional Evaluation(s)
    - Psychological Report(s)
    - Individualized Education Program from schools
    - School records
    - Physician diagnosis and remarks
    - Existing evaluation done by Supplemental Security Income or Vocational Rehabilitation
    - IQ testing done at any time
- Medicaid application for individuals over eighteen (18) years of age
- Supplemental Security Income application, if applicable

- A LOCSI will be used to assess any individual six (6) years of age and older.
- An individual must meet:
  - the State definition of a developmental disability found in IC 12-7-2-61(a); and
  - Intermediate Care Facility for the Intellectually Disabled (ICF/ID) Level of Care (LOC) found in 42 CFR §435.1010.
- If an individual completes the application and meets the LOC criteria listed in Section 5.3 above, they will be placed on the waiting list using the individual's application date.

Waiting List Targeting for a Waiver Slot

- Individuals will be targeted for a Family Supports Waiver slot from the single statewide waiting list using the individual's application date.
- Individuals will be targeted in the order they applied for services, from the oldest date of application to newest.
- Individuals ages 18 through 24 who have aged out of, graduated from or have permanently separated from their school setting may be able to enter waiver services under the Family Supports Waiver upon that separation if funded slots are available.

Note that entrance into services under the Community Integration and Habilitation Waiver now occurs only by meeting certain priority criteria known as Reserved Capacity.

Responsibilities of Individuals on the Waiting List

- An individual, or an individual's legal representative, is expected to maintain current contact information with their local BDDS office. This shall include any change in address or telephone number.

- If BDDS attempts to contact an individual or the individual's legal guardian and the identified secondary contact person and is unable to make contact by mail or telephone, the individual may be removed from the waiting list.

Children under the Age of Six (6)

- A parent or guardian may apply for Home and Community Based Services (HCBS) at any time after a child's birth.
- Children under the age of six (6) years old will have their information input into the BDDS database along with date of application.
- Once a child turns six (6) years old, families will have two (2) years to come into their local BDDS office and complete a LOCSI.
- If upon the child's eighth (8th) birthday a LOCSI has not been completed, the child will lose his/her original application date.
- It is the family's responsibility to ensure that the local BDDS office receives adequate information to complete the LOCSI within the timeframe.
- If the child's LOCSI is completed by the age of eight (8) and BDDS determines that the child meets the criteria for HCBS waiver services, the child will be placed on the single statewide waiting list with <u>their original application date</u>.

<u>Section 5.5: Targeting Process for the Family Supports Waiver</u>

When a slot becomes available under the Family Supports Waiver, an individual on the single statewide waiting list will receive a letter from BDDS Central Office, asking them to accept or decline the waiver slot, apply for Medicaid if he/she hasn't already, and provide or obtain confirmation of their diagnosis from a physician on the DDRS form known as the 450B. A response accepting or declining the waiver slot must be received within 30 days.

Individuals ages 18 through 24 who have aged out of, graduated from or have permanently separated from their school setting may be able to enter waiver services under the Family Supports Waiver upon that separation if funded slots are available.

If an individual declines the offer for a Family Supports Waiver slot, his or her name is removed from the single statewide waiting list.

If an individual accepts the offer for a Family Supports Waiver slot:

- An intake meeting at the local BDDS District Office is scheduled for the BDDS and/or its eligibility contractor to complete the following:
    - Collateral information, provided by the individual, is reviewed and level of care, again, established

    - LOCSI is completed
- The individual/guardian must obtain confirmation of their diagnosis on a 450B form signed by their physician within 21 days from date of letter
- The individual/guardian has 60 days to apply for/obtain Medicaid when the individual does not yet have Medicaid coverage
- If the individual already has Medicaid coverage, but the Aid Category to which the individual's Medicaid eligibility has been assigned is not compatible with waiver program requirements, he or she has 30 days from the date on the contact letter from BDDS to request that the DFR process the needed change in Medicaid Aid Category
- The individual/guardian must cooperate fully with requests related to the application for Medicaid eligibility and/or any needed change in Medicaid Aid Category

Once all assessments have been made, applicants under the age of 18 and their legal guardians are given a pick list by BDDS containing providers of Case Management services that are approved by DDRS to provide service in the applicant's county of residency. Due to the disregard of parental income for minors receiving waiver services, proof of an approved Plan of Care/Cost Comparison Budget (CCB) may be required before some minors can obtain Medicaid eligibility, and the selection of a Case Manager is required before the CCB can be created. For adults, generation of the Case Management agency pick list by BDDS and selection of a Case Management agency will not occur until after all eligibility criteria are met, including establishment of Medicaid eligibility in a waiver-compatible Aid Category. Thereafter, the applicant/guardian (if applicable) completes the service planning process, chooses a service provider(s), and the Case Manager submits a CCB for waiver service.

Once the pick list is provided by BDDS, the individual/guardian has:

- five (5) days to interview and choose a permanent case manager
- 14 days to interview and choose, at minimum, one provider

From the date a provider is chosen, the individual/guardian has:

- 14 days to complete the service planning process enabling the CCB to be created, and
- once CCB is completed, the individual/guardian (consumer) has three (3) days to review and sign service planning documents

If the individual is unable to start waiver services within the given timeframes, the individual may be removed from the targeting process.

Note: Entrance into services under the Community Integration and Habilitation Waiver program now occurs only by meeting certain priority criteria known as Reserved Capacity.

Section 5.6: Entrance into the Community Integration & Habilitation Waiver Program

As of September 1, 2012, entrance into the Home and Community Based Services (HCBS) waiver program known as the Community Integration and Habilitation (CIH) Waiver requires the individual to meet and be approved for certain, specific and federally approved priority criteria known as Reserved Capacity categories within the CIH Waiver.

- To move onto the needs-based CIH Waiver, an individual must meet and be approved for the specific priority criteria of at least one of the following categories:
    - Eligible individuals transitioning to the community from NF, ESN and SOF
    - Eligible individuals determined to no longer need/receive active treatment in an SGL
    - Eligible individuals transitioning from 100% state funded services
    - Eligible individuals aging out of DOE, DCS or SGL
    - Eligible individuals requesting to leave a Large Private ICF/ID
    - Eligible individuals meeting the following emergency criteria:
        - Death of a Primary Caregiver where there is no other caregiver available, or
        - Caregiver over 80 years of age where there is no other caregiver available, or
        - Evidence of abuse or neglect in the current institutional or SGL placement, or
        - Extraordinary health and safety risk as reviewed and approved by the Division Director

- Individuals, their legal representative or other persons acting on their behalf must request a priority waiver slot when it appears that the individual meets the specific criteria of one or more Reserved Capacity categories
- It is necessary to complete an application and submit the application to their local BDDS office to apply for HCBS waiver services.
- The Individual and/or any legal guardian is expected to participate in the completion of the following:
    - Application
    - Collateral Information, including the following:
        - Level of Care Screening Instrument (LOCSI)
        - Supporting documents:
            - Diagnostic Evaluation(s)
            - Functional Evaluation(s)

        - Psychological Report(s)
        - Individualized Education Program from schools
        - School records
        - Physician diagnosis and remarks
        - Existing evaluation done by Supplemental Security Income or Vocational Rehabilitation
        - IQ testing done at any time
    - Medicaid application for individuals over eighteen (18) years of age
    - Supplemental Security Income application, if applicable
- A LOCSI will be used to assess any individual six (6) years of age and older.
- An individual must meet:
    - the State definition of a developmental disability found in IC 12-7-2-61(a); and
    - Intermediate Care Facility for the Intellectually Disabled (ICF/ID) Level of Care (LOC) found in 42 CFR §435.1010.
- Additionally, if an individual meets the LOC criteria listed in Section 5.3 above, and a funded priority slot is available in the Reserved Capacity category met by the individual, the BDDS Office will first determine whether or not other potential placement options have been exhausted before offering the slot to the individual
- Individuals are responsible for maintaining current collateral and contact information with their local BDDS office.

Waiting List for a CIH Waiver Priority Slot

- Priority access by reserve capacity category is made available only as long as priority waiver slots in the specific reserve capacity category remain open. Once the priority waiver slots in a specific reserve capacity category are filled, individuals meeting the priority access criteria for that category will be placed on the waiting list for that category. They will subsequently be tracked based on their need and offered a waiver slot when a newly available priority waiver slot for which they qualify becomes available.

Responsibilities of Individuals who are on the Waiting List for a CIH Waiver Priority Slot

- An individual, or an individual's legal representative, is expected to maintain current contact information with their local BDDS office. This shall include any change in address or telephone number.
- If BDDS attempts to contact an individual or the individual's legal guardian and the identified secondary contact person and is unable to make contact by mail or telephone, the individual may be removed from the CIH Waiver priority slot waiting list.

If an individual declines placement offered through a funded CIH Waiver priority slot, his or her name is removed from the CIH Waiver priority slot waiting list.

If an individual accepts placement through the offer of a funded CIH Waiver priority slot:

- An intake meeting at the local BDDS District Office is scheduled for the BDDS and/or its eligibility contractor to complete the following:
    - Collateral information, provided by the individual, is reviewed and level of care, again, established
    - LOCSI is completed
    - Allocation is recorded into system
- The individual/guardian must obtain confirmation of their diagnosis on a 450B form signed by their physician within 21 days from date of letter
- The individual/guardian has 60 days to apply for/obtain Medicaid when the individual does not yet have Medicaid coverage
- If the individual already has Medicaid coverage, but the Aid Category to which the individual's Medicaid eligibility has been assigned is not compatible with waiver program requirements, he or she has 30 days from the date on the contact letter from BDDS to request that the DFR process the needed change in Medicaid Aid Category
- The individual/guardian must cooperate fully with requests related to the application for Medicaid eligibility and/or any needed change in Medicaid Aid Category

Once all assessments have been made, applicants under the age of 18 and their legal guardians are given a pick list by BDDS containing providers of Case Management services that are approved by DDRS to provide service in the applicant's county of residency. Due to the disregard of parental income for minors receiving waiver services, proof of an approved Plan of Care/Cost Comparison Budget (CCB) may be required before some minors can obtain Medicaid eligibility, and the selection of a Case Manager is required before the CCB can be created. For adults, generation of the Case Management agency pick list by BDDS and selection of a Case Management agency will not occur until after all eligibility criteria are met, including establishment of Medicaid eligibility in a waiver-compatible Aid Category. Thereafter, the applicant/guardian (if applicable) completes the service planning process, chooses a service provider(s), and the Case Manager submits a CCB for waiver service.

Once the pick list is provided by BDDS, the individual/guardian has:

- five (5) days to interview and choose a permanent case manager
- 14 days to interview and choose, at minimum, one provider

From the date a provider is chosen, the individual/guardian has:

- 14 days to complete the service planning process enabling the CCB to be created, and
- once CCB is completed, the individual/guardian (consumer) has three (3) days to review and sign service planning documents

If the individual is unable to start CIH Waiver services within the given timeframes, the individual may be removed from the process, resulting in the available CIH Waiver priority slot being offered to another individual who is in need of services.

Section 5.7: Initial Plan of Care/Cost Comparison Budget (CCB) Development

The Plan of Care/Cost Comparison Budget (CCB) is developed based upon the outcomes of the initial, annual or subsequent meeting of the Individualized Support Team during which the Person-Centered Plan and the Individualized Support Plan are developed. This entire process is driven by the individual/participant and is designed to recognize the participant's needs and desires. The Case Manager holds a series of structured conversations, beginning with the participant/ guardian and with other individuals, identified by the participant that know them well and can provide pertinent information about them, to gather initial information to support the person-centered planning process. The overall emphasis of the conversations will be to derive what is important to and what is important for the participant, with a goal of presenting a good balance of the two. The case manager facilitates the IST meeting, reviews the participant's desired outcomes, their health and safety needs and their preferences, and reviews covered services, other sources of services and support (paid and unpaid) and the budget development process for waiver services. The case manager then finalizes the ISP and completes the CCB. (See **Section 1.11: Helpful Hints for Participants and Guardians on How to Select Waiver Providers** found in **PART 1** of this manual.)

While the Family Supports Waiver is already capped at $16,250 annually, budgeted amounts for CCBs developed under the Community Integration and Habilitation Waiver use the objective based allocation process described under **PART 6** of this manual.

Coordination of Waiver Services and other services is completed by the Case Manager. Within 30 days of implementation of the plan, the Case Manager is responsible for ensuring that all identified services and supports have been implemented as identified in the Individualized Support Plan and the CCB. The Case Manager is responsible for monitoring and coordinating services on an ongoing basis and is required to record a case note for each encounter with the participant. A formal 90 day review is also completed by the case manager with the participant and includes the IST.

Most waiver service providers are required to submit a monthly or quarterly report summarizing the level of support provided to the participant based upon the identified supports and services in the Individualized Support Plan and the Cost Comparison Budget. As part of the 90 day review process, the Case Manager reviews these reports for consistency with the ISP and CCB and works with providers as needed to address findings from this review.

Section 5.8: State Authorization of the Initial CCB

The Case Manager will transmit the Plan of Care/Cost Comparison Budget (CCB) electronically to the State's Waiver Specialist who will review the CCB and Service Planner and confirm the following:

- The individual is a current Medicaid recipient within one of the following categories
  - Aged **(MA A)**
  - Blind **(MA B)**
  - Low Income Families **(MA C)**
  - Disabled **(MA D)**
  - Disabled Worker **(MA DW)**
  - Children receiving Adoption Assistance or Children receiving Federal Foster Care Payments under Title IV E - Sec. 1902(a)(10)(A)(i)(I) of the Act **(MA 4 & MA 8)**
  - Children receiving adoption assistance under a state adoption agreement - Sec 1902(a)(10)(A)(ii)(VIII) **(MA 8)**
  - Independent Foster Care Adolescents – Sec 1902(a)(10)(A)(ii)(XVII) **(MA 14)**
  - Children Under Age 1 – Sec 1902(a)(10)(A)(i)(IV) **(MA Y)**
  - Children Age 1-5 - Sec 1902(a)(10)(A)(i)(VI) **(MA Z)**
  - Children Age 1 through 18 - Sec 1902(a)(10)(A)(i)(VII) **(MA 9 & MA 2)**
  - Transitional Medical Assistance – Sec 1925 of the Act **(MA F)**
  - Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121 **(MA U)**

- The individual has a current ICF/ID level of care approval

- The individual has been targeted for an available waiver slot;

- The individual's indentified needs will be met and health and safety will be assured;

- That if the total cost of Medicaid waiver and regular Medicaid State plan services for the individual exceeds the total costs of serving an individual with similar needs in an ICF/ID facility, the programmatic cost-effectiveness will be maintained;

- The individual or guardian has signed, indicating acceptance of, the CCB; signed that he/she has been offered choice of certified waiver service providers; and signed that he/she has chosen waiver services over services in an institution.

The Waiver Specialist may request additional information from the Case Manager to assist in reviewing the CCB.

If the Waiver Specialist approves the Initial CCB, the Initial approval letter and Notice of Action are electronically transmitted to the Case Manager, BDDS (for Initials and Annuals only) and Service Providers. Within three (3) calendar days of receiving the Initial CCB approval letter, the Case Manager must print a Notice of Action form (HCBS Form 5) and sign it. The Case Manager must provide copies of the approval letter, the signed Notice of Action form and Addendum (containing information from the CCB and Person Centered Service Planner) to the individual participant/guardian. The participant's chosen waiver service providers are required to register so that they receive the Notices of Action and the Addendums electronically.

The Notice of Action serves as the official authorization for service delivery and reimbursement.

If the Waiver Specialist approves the CCB pending Medicaid eligibility or change of Aid Category (for minors only), disenrollment of a child from Hoosier Healthwise, facility discharge, or other reasons, the pending approval letter is to be transmitted to the Case Manager, BDDS and Service Providers. The Case Manager must notify the individual or guardian within three (3) calendar days of receipt of the pending approval and provide a copy of the Initial approval letter naming the pending conditions. No Notice of Action is generated until all pending issues are resolved and a final approval letter is released.

If the Waiver Specialist denies the Initial CCB, a denial letter must be transmitted to the Case Manager, BDDS (for Initials and Annuals only) and Service Providers. Within three (3) calendar days of receipt of the denial the Case Manager must complete and provide a copy of a Notice of Action (HCBS Form 5), the Appeal Rights as an HCBS Waiver Services Recipient, and an explanation of the decision to deny to the individual participant/guardian. The case manager will discuss other service options with the individual and guardian and the individual's name should be removed from the waiting list, unless the individual participant or guardian files an appeal.

NOTE: *Once waiver services begin, waiver participants are sometimes referred to as consumers.*

Section 5.9: Initial Service Plan Implementation

An individual cannot begin waiver services under the Family Supports Waiver program or the Community Integration and Habilitation Waiver program prior to the approval of the Initial Plan of Care/Cost Comparison Budget (CCB) by the State's Waiver Specialist. The Initial CCB represents the service plan identified for the individual as the result of the person-centered description and the individualized support plan development process. If the Waiver Specialist issues an Initial approval letter pending certain conditions being met, those conditions must be resolved prior to the start of the individual's waiver services. For applicants under the age of 18, if the individual's Medicaid eligibility is approved pending waiver approval, the Case Manager will notify the local DFR Caseworker when the waiver has been approved. The DFR Caseworker and waiver Case Manager coordinate the Medicaid eligibility date and waiver start date. If Medicaid eligibility depends on eligibility for the waiver, the Medicaid start date is usually the first day of the month following approval of the CCB.

If an individual is a Hoosier Healthwise or Medicaid managed care program participant other than Care Select, the Case Manager must contact the local DFR Caseworker to coordinate the managed care program stop date and waiver services start date. Individuals receiving the Indiana Health Care Hospice benefit do not have to disenroll from this benefit to receive waiver services that are not related to the terminal condition and are not duplicative of hospice care. If applicable, the Case Manager and managed care benefit advocate must inform the individual

and individual's parent or guardian of his/her options to assure he/she makes an informed choice.

When the CCB is approved by the Waiver Specialist pending facility discharge, the waiver start date can be the same day that the individual is discharged from the facility.

Following discharge from the facility and within three (3) calendar days after the individual begins waiver services, the Case Manager must complete the Confirmation of Waiver Start form in the INsite database and electronically transmit it to the State through the DDRS INsite database.

For all waiver starts, when the Case Manager completes the *Confirmation of Waiver Start* form in the Insite database and electronically transmits it to the DDRS database, the Office of Medicaid Policy and Planning (OMPP) will also be electronically notified to enter the individual's waiver start information in the Indiana AIM database.

When the *Confirmation of Waiver Start* form is received electronically by DDRS, the form is reviewed and, if accepted, an approval letter will be automatically transmitted back to the Case Manager. The period covered by the Initial CCB will be from the effective date of the *Confirmation* form through the end date of the Initial CCB that was previously approved by the Waiver Specialist.

Within three (3) calendar days of receiving the Initial CCB approval letter, the Case Manager must print a Notice of Action form (HCBS Form 5) and sign it. The Case Manager must provide copies of the signed Notice of Action form and Addendum (containing information from the CCB and Person Centered Service Planner) to the individual/guardian. The individual's chosen waiver service providers are required to register so that they receive the Notices of Action and the Addendums electronically.

There is no reimbursement for services delivered prior to receipt of the Notice of Action.